Overview of Psychiatric Rehabilitation Education: Concepts of Training and Skill Development

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Abstract. *Training in psychiatric rehabilitation, at both preservice and in-service levels, has not kept pace with the developing knowledge base in psychiatric rehabilitation. Currently, the psychiatric rehabilitation field has a clear mission and philosophy and a defined population in need of psychiatric rehabilitation services. Now it must develop in its workforce the specific competencies (knowledge, attitude, and skills) that can effectively deliver services to individuals with psychiatric disabilities.- Educators must understand the empirical basis of the field, the practitioner tasks that are most apt to relate to improved client outcomes, and the various types of training programs that are possible.*

Historically, mental health and rehabilitation training programs, both in-service and preservice, have not placed a high value on training staff to serve people with severe psychiatric problems (Farkas & Furlong-Norman, 1995). Many authors have lamented the lack of interest among the "core disciplines" (social work, psychology, nursing, psychiatry) in developing personnel trained to work with people who have severe psychiatric disabilities (e.g., Anthony, Cohen, Farkas, & Gagne, 2000; Goldman, 1996; Johnson,1990). Rehabilitation counseling programs have not been far ahead of these core disciplines in their development. Two surveys of accredited rehabilitation counseling programs, developed 17 years apart, found that the majority of programs did not offer even one course in psychiatric rehabilitation (McReynolds, Garske, & Turpin, 1999; Weinberger & Greenwald, 1982).

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The lack of enthusiasm for providing training in psychiatric rehabilitation is due to several factors. A perception has existed that people with severe psychiatric disabilities were inappropriate candidates for psychotherapy because they lacked successful outcomes in relation to traditional treatment. Sparse funding for varied programs to serve this population also has contributed to the lack of support for training and continuing education of personnel (Farkas & Anthony, 1993; Farkas & Furlong-Norman, 1995). Prior to the development of community support systems, funding provided by state departments of mental health typically focused on inpatient treatment modalities. However, the shift toward community-based programs resulted in a growing demand by state mental health agencies for workers with the required knowledge and skills to staff them (Bevilacqua, 1984). The shift toward community-based care also enhanced the growth of psychiatric rehabilitation programs, creating a further demand for trained personnel.

With the advent of behavioral health care in the United States and its emphasis on accountability, renewed emphasis has been placed on the competencies of those delivering mental health and rehabilitation services to people with severe psychiatric disabilities. Increasingly, mental health programs are under pressure to hire, train, and retain staff who can deliver quality services (Coursey, 1998; Hewitt & Larson, 1994; Hewitt, Larson, & O'Nell, 1996; Taylor & Ashbaugh, 1997). The National Task Force on Human Resource Development (1993) called for the development of training curricula that emphasize competencies defined in terms of service requirements, rather than focus on disciplinary traditions. In order to specify a curriculum, educators must understand who the consumers (the target population) and the providers are.

The Target Population

The International Association of Psychosocial Rehabilitation Services (IAPSRS) conservatively estimated that 2.6% of the United States population has a psychiatric disorder severe enough to cause disability (IAPSRS, 1997). Several definitions of severe psychiatric disability characterize this target population; yet most share common elements such as a diagnosis of mental illness, prolonged duration, and major functional incapacity (e.g., Goldman, Gattozzi, & Taube, 1981). It is now also possible to operationalize these common elements (IAPSRS, 1997; Ruggeri, Leese, Thornicroft, Bisoffi, & Tansella, 2000). For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has defined major functional impairment as including one of the following:
1. Either planned or attempted suicide at some time during the past 12 months;
2. OR lacked a legitimate productive role;
3. OR had a serious role impairment in their main productive roles;
4. OR had serious interpersonal impairment as a result of being totally socially isolated: lacking intimacy in social relationships, showing inability to confide in others and lacking social support. (IAPSRS, 1997, p. 1)

People who have psychiatric disabilities are not simply individuals who are dissatisfied, unhappy, or "socially disadvantaged." People with psychiatric disabilities have diagnosed psychiatric experiences that limit their capacity to perform certain tasks

and functions (e.g., interacting with family and friends, interviewing for a job) and their ability to perform in certain roles (e.g., worker, student). Within this population are a variety of subpopulations, such as young adults (e.g., Harris & Bergman, 1987; Pepper & Ryglewicz, 1984), people from minority cultures (e.g., Musser-Granski & Carillo, 1997), people who are homeless (e.g., Salit, Kuhn, Hartz, Vu, & Mosso, 1998) or otherwise impoverished (e.g., Ware & Goldfinger, 1997), senior citizens (e.g., Gaitz, 1984), people with both a severe physical disability and a severe psychiatric disability (e.g., Pelletier, Rogers, & Thurer, 1985), people who also have developmental disabilities (e.g., Reiss, 1987), and people with substance abuse problems (e.g., Mercer-McFadden et al., 1998; Struening & Padgett, 1990).

Practitioners Working with People with Severe Psychiatric Disabilities

Professionals across all disciplines provide services for people with severe psychiatric disabilities. National statistics compiled by the Center for Mental Health Services (Manderscheid & Henderson, 1998) began reporting on the workforce in the psychosocial field in 1994. In the field of psychiatric or psychosocial rehabilitation alone there has been an almost threefold increase in the supply of workers from 35,000 in 1994 to 100,000 in 1996 (Peterson et al., 1998). In an effort to understand more about who comprises the pool of personnel available to psychosocial rehabilitation programs, Blankertz and Robinson (1996) surveyed 9,437 psychosocial rehabilitation workers in the United States. Of these workers 77% were in direct service, 14% held supervisory positions, and 8% were in administration. One third of those providing direct service did not hold college degrees. A large percentage of supervisory staff (45.7%) had graduate degrees and the majority of administrators also had graduate degrees (55.5%).

The Blankertz and Robinson (1996) survey also showed that 40% of the psychosocial rehabilitation workforce was trained in the core disciplines. The rest were trained in rehabilitation counseling, mental health counseling, and other fields (Blankertz, Robinson, Baron, Hughes, & Rutman, 1995).

In terms of ethnic background, Peterson et al. (1998) were only able to provide a breakdown of data for the males in the workforce in 1994, even though the workforce was predominantly female. In those data, 38.4% were male. Of these, 69.8% were Caucasian, 20.8% were Black, and 6.4% were of Hispanic origin, 2.0% were Asian or Pacific Islanders, and 0.4% was American Native. Blankertz and Robinson (1996) also found that the workforce in their sample was predominantly female. Within their sample, however, they found an even larger Caucasian workforce (81%) than Peterson et al. and found that 11% were African American, 4% were Hispanic, and 2 % were Asian.

Increasingly, mental health consumers are being hired as providers of mental health services (Mowbray & Moxley, 1997). Hiring consumers as mental health providers is seen as a natural evolution and an expansion of the consumer role (Solomon & Draine, 1998). Consumer-oriented and consumer-provided services are seen as a fundamental aspect of a progressive mental health system (Anthony, in press). The inclusion of consumers in the mental health and rehabilitation workforce has been occurring over the past 10 years at every level of service provision—from direct service to administrative and supervisory roles (Zipple et al., 1997). Clearly, the psychosocial

workforce contains a wide range of diversity—diversity in educational levels, diversity in racial and ethnic composition, and diversity in personal psychiatric experience.

Developing Competent Staff

Educating such a heterogeneous group of mental health and rehabilitation personnel requires a clear curriculum that overcomes the prevailing negative view that people with severe psychiatric disabilities cannot benefit from services and one that can respond to the diversity within the client group as well as within the workforce. A well-developed curriculum also can serve to unite staff, regardless of discipline or background characteristics, around a single mission and philosophy of psychiatric rehabilitation.

The Mission and Philosophy of Psychiatric Rehabilitation

The mission of psychiatric rehabilitation is *to help people with psychiatric disabilitie*s *increase their functioning so that they can be successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention* (Anthony, Cohen, & Farkas, 1990b; Anthony et al., 2001). The primary values in the field have been described by various authors (Cnaan, Blankertz, Messinger, & Gardiner, 1990; Farkas, Anthony, & Cohen, 1989) and are inherent in the mission statement. These values include, but are not limited to, *person orientation* (a focus on the individual*), consumer choice* and *involvement* in the process, a focus on *functioning* and *support* in *real world environments*, and a focus on *outcomes* rather than theory.

Outcome Research Related to Working with People with Severe Psychiatric Disabilities

Over the past three decades, an emerging body of research has provided direction for how best to intervene with people who have severe psychiatric disabilities (Anthony et al., 2001). Empirically based findings can now be used as a guide for the development of training curricula. Implicit in these findings are suggestions for the skills that professionals should be developing during their psychiatric rehabilitation education. A number of research reviews done over the past 20 years supported the following points as fundamental to the field. The following eight empirical findings represent an expansion of the research summary originally developed by Anthony, Cohen, and Farkas (1990a):

1. People with severe psychiatric disabilities can live in the community with the minimal utilization of inpatient services.
2. People with severe psychiatric disabilities can be helped to function more successfully in the community by means of skill and support development interventions.
3. The psychiatric diagnoses and particular symptom patterns of people with severe psychiatric disabilities are not highly correlated with successful community functioning. In contrast, measures of skills and supports often are related to community outcome.

4.   The community functioning of people with severe psychiatric disabilities can be improved by means of increased collaboration between agencies and settings (e.g., Department of Mental Health and Division of Vocational Rehabilitation, inpatient and outpatient). Existing resources, if used effectively, can have an impact on outcome.

5.   Improved community functioning in one area of a person's life does not indicate that the person's functioning in other life areas has been similarly affected. The person's goals in each area—living, learning, and working—must be addressed specifically.

6.   The longer the research follow-up period, the more dramatic the effect that skills and support development interventions have on the community functioning of people with severe psychiatric disabilities. It may take time for interventions to have an effect on people with severe psychiatric disabilities.

7.   The typical prognosis is not increasing deterioration between episodes, but rather, gradual improvement over the long term. A chronic or severe impairment does not mean total or lifelong disability; it may only increase the risk.

8.   The helping relationship is one of the most potent ingredients of effective rehabilitation. Regardless of the degree of impairment, the strength of the relationship has been shown to have a correlation between practitioner and client measures of process and outcome.

Core Competencies Related to Working with People with Severe Psychiatric Disabilities

A plethora of associations and committees have worked over the past 10 years to identify the necessary "core competencies" of psychiatric rehabilitation (e.g. American Nurses Association, 1995; American Psychiatric Association, 1995; Carling & Curtis, 1993; Coursey et al., 2000; IAPSRS, 1997; Taylor, Bradley, & Warren, 1996). Core competencies have been defined as "the essential values, attitudes, ethical principles, knowledge, and skills that mental health providers need to function effectively" (Zubritsky & Hadley, 1998, p. 75). While core competencies have been specified, empirically based curricula to teach these competencies have rarely been developed. Research relating to outcomes for people with serious psychiatric disabilities can provide a solid base for curriculum development in psychiatric rehabilitation.   The eight empirical findings described earlier suggest the following tasks and skills as central to working with people with serious psychiatric disabilities: setting goals relevant to where they wish to live, learn or work in the community (setting an overall rehabilitation goal); assessing what skills and supports they need (functional assessment and resource assessment); learning new skills specifically related to the goals they have (direct skills teaching); using the skills they have and incorporating them into daily life (skills use programming); linking up with supports they need to achieve the goals they have (rehabilitation case management); connecting and developing the experience of support over time (interpersonal skills, e.g., empathy, self-disclosure, disagreeing). These tasks and related skills form the basis of psychiatric rehabilitation practice (Anthony et al., 2001).

Developing Curricula

With improved client outcome as the main reason for a particular curriculum, a preservice or in-service curriculum can help a practitioner develop the knowledge, attitudes, and skills relevant to performing those outcome-related tasks. Examples of knowledge relevant to psychiatric rehabilitation include recovery, the psychiatric rehabilitation process, the consumer movement, cross-cultural issues, and the research related to each of the above. The kinds of attitudes that are relevant in to psychiatric rehabilitation are contained in the philosophy and values of psychiatric rehabilitation (Farkas & Anthony, 1980; Goldman, 1996). For example, practitioners need to have a positive view about the individual's potential for growth, the right of the individual to be fully involved in the rehabilitation process, and the importance of client choice. It is important that the practitioners view the competencies they acquire as a primary method of expressing these values in daily practice.

With respect to practitioner skill development, existing training programs vary in terms of the intensity of the professional training experience. Some programs directly teach psychiatric rehabilitation skills. These programs explain the steps for skill performance, demonstrate skill performance, and offer supervised opportunities for practice. Other programs simply provide general knowledge about psychiatric rehabilitation, but provide no skills training. Still others provide both the knowledge and supervised fieldwork, but neglect systematic instruction in the field. Anthony et al. (1990a) have proposed a way of categorizing preservice programs that teach students about rehabilitation of persons with severe psychiatric disabilities. Curricula of these programs can be categorized with respect to their level of intensity: *exposure, experience,* and *expertise*.

Exposure training involves didactic training only. The goal in exposure training is to provide information. Lectures, reading courses, and presentations are often the vehicle for exposure level training. Farkas and Furlong-Norman (1995) surveyed both in-service and academic training programs in the United States and Canada. Fifty-eight academic programs and 392 in-service programs were contacted. Of the responding 31 academic programs and 46 in-service programs that were, in fact, focused on psychosocial competency areas, all provided exposure-level training.

Experience training involves brief visits, internships, or experiential workshops on various topics to help the targeted audience to develop an image, a new outlook, or a new attitude toward the topic. While adding some experience-level coursework to an exposure-training program requires a greater level of effort and resources than exposure-level coursework, this level of intensity is common in training programs with a clinical focus on people with severe psychiatric disabilities (Goldman, 1996). Farkas and Furlong-Norman (1995) found that 56 of the 77 training programs that responded, or slightly more than 72%, provided both exposure and experience. The pairing of knowledge and emotionally relevant experiences with the target population has been identified as a powerful tool in developing openness among frontline workers to the incorporation of psychiatric rehabilitation interventions (Gask & Eurelings-Bontekoe,

1995). Experience training also has proved useful in developing curricula that sensitize trainees to the needs and contributions of people from different racial and ethnic backgrounds and of people with personal psychiatric experiences. Wheaton and Granello (1998) studied the effects of training in multicultural competencies on 180 vocational rehabilitation counselors, using the Multicultural Counseling Inventory (Sodowsky, Taffe, Gutkin, & Wise, 1994). They found that while "classroom" training (exposure and expertise) did affect knowledge, skills, and awareness, only experience seemed to impact on attitudes related to multicultural issues. Furthermore, a randomized evaluation of in-service training for mental health professionals conducted by consumers or nonconsumers found that posttraining attitudes were significantly more positive for participants trained by a consumer (Cook, Jonikas, & Razzano, 1995). Consumer trainers not only were able to add their special insights to the more traditional lecture formats, but also to provide students with an experience of consumers in different roles (Lefly, 1997). *Expertise training* is the most intense training format. It involves skill development and behavior change on the part of the participants. It requires intensive supervision, practice, feedback, didactic presentations, and exercises. Curricula exist that support educators in their delivery of expertise training (Cohen, Forbess, & Farkas, 2000; Cohen, Nemec, & Farkas, 2000; Cohen, Farkas, Cohen, & Unger, 1994; Cohen, Nemec, Farkas, & Forbess, 1988; Cohen, Farkas, & Cohen, 1986; Cohen, Danley, & Nemec, 1985; Farkas, Cohen, McNamara, Nemec, & Cohen, 2000; Farkas, Sullivan-Soydan, & Gagne, 2000). Expert practitioners can demonstrate their psychiatric rehabilitation skills by means of audio- or videotapes of their sessions with clients (Rogers, Cohen, Danley, Hutchinson, & Anthony, 1986). Typically, however, expertise training requires a developmental program over a number of years. The extent of supervision and the intensity of expertise-level training have discouraged many programs from including skill development in their curriculum. Farkas and Furlong-Norman's 1995 survey found that of the 31 academic programs that responded, only one provided expertise training (Farkas, O'Brien & Nemec, 1988; McNamara, Nemec, & Farkas, 1995). Skill development can itself be seen as occurring along a continuum, from readiness to learn a skill to maintenance of expertise in the skill (Table 1).

Many training programs have difficulty because they expect expertise-level outcomes from exposure-level curricula. Educational programs often report difficulties finding the time to provide expertise-level training (Farkas & Anthony, 1990). Substantial time is required, particularly if the trainees or students are not ready to learn the particular content area. Trainees who believe their current practice is effective, or who believe that nothing can be done for people with severe psychiatric disabilities, are not ready to learn psychiatric rehabilitation. For these students and staff, exposure-level training is often too intense. Mentoring, simple exposure to new literature, or performance evaluations can confront people with their actual level of effectiveness and can often help to develop their readiness.

Academic programs can often easily provide introductory expertise training by helping students to perform skills correctly in a role play or simulated setting (acquisition), even if providing higher levels of expertise training proves difficult. Designing curricula to

Table 1
Skill Development Continuum

Level of mastery (lowest to highest)	Definition	Training intensity methods needed to produce level of mastery
Readiness	Dissatisfied with current skill practice and looking for new skills *or* simply curious about the possibility of new skills and therefore ready to learn.	Performance evaluation, mentoring, sharing literature on the ideas can help develop trainee's readiness to learn a new skill.
Awareness	Has an image of what the skill is and what it might look like if performed.	Exposure- and experience-level training can be helpful in developing awareness.
Acquisition	Can perform a skill at least once correctly in a simulated environment, like a classroom setting.	Introductory-level expertise training can develop acquisition.
Application	Can perform a skill at least once correctly with an actual client, preferably a client of the trainee; may use prompts or worksheets.	More intensive expertise training provides supervision, feedback on at least one practice with an actual client.
Utilization	Uses the skill on a daily basis in an actual setting where clients are being helped.	Expertise training focused on follow-up supervision and feedback, consultation to help the organization incorporate and reward the use of new skills are needed.
Maintenance	Able to perform consistently at the level of expertise that she or he has acquired.	Expertise training to develop the person's ability to discriminate own skill performance. Organization needs to have policies, procedures, activities, record keeping, and performance evaluation that all require the use of the skills.

educate students who can, with support, demonstrate the skills with actual clients (application) requires the availability of good internship sites that are also using the particular competencies being taught in the training program in question. The effective utilization of skills in daily practice has more requirements that are stringent. In fact, skill utilization is not dependent upon training alone. It requires good supervision and agency management techniques that support and reward the delivery of effective psychiatric rehabilitation services.

In summary, the literature attests to the historical omission of content relevant to people with severe psychiatric disabilities in the curricula of most professional training programs. The service delivery settings want and need better-trained professionals, but the educational settings have not yet delivered the needed personnel (Caldwell, Fishbein, & Woods, 1994). The inclusion of providers with a variety of backgrounds, including varied racial and ethnic groups and individuals who have personal psychiatric experiences, increases the breadth and scope of the training requirements (Musser-Granski & Carrillo, 1997; Smart & Smart, 1994; Solomon & Draine, 1998). The Registry for Psychiatric Rehabilitation Practitioners (IAPRS, 1997) implemented by the International Association of Psychosocial Rehabilitation Services identifies practitioners who meet rigorous standards set by the organization. Over time, the Registry will increase the demand for clear training programs that produce effective practitioners. The concepts of *exposure, experience, and expertise* can help educators design specific curricula to achieve specific goals. Focusing on practitioner skill development can help both educators and service administrators clarify their expectations and requirements for performance. Finally, psychiatric rehabilitation education, when it remains committed to learn from the people it is designed to help, ultimately empowers professionals, family members, and consumers alike with the necessary skills, knowledge, and attitudes to achieve important life goals.

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